

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151509		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/20/2015	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 619 W 1ST ST BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{L 000}	<p>INITIAL COMMENTS</p> <p>This was a revisist for a federal and state hospice complaint investigation.</p> <p>Complaint ID # IN00163364 - Substantiated: federal and state deficiencies related to the allegations were cited. Unrelated deficiencies were also cited</p> <p>Facility # IN005811</p> <p>Medicaid # 200141660</p> <p>Survey Date 4/20/2015</p> <p>During this survey, 2 Conditions of Participation and 9 standard level deficiencies were found corrected.</p> <p>Indiana University Health Hospice is in compliance with the Conditions of Participation 42 CFR 418.</p> <p>QA: JE: 4/21/15</p>			{L 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.